

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

43690

Registration District No. 735

Primary Registration District No. 5795 4453

Registrar's No.

1. PLACE OF DEATH

- (a) County St Charles  
(b) City or town Augusta Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days 2

3. (a) PRINT FULL NAME Robert L. Parks

8. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security \_\_\_\_\_  
name war \_\_\_\_\_ No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Parks 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Apr. 9 1863  
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Batesville Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Wm. Parks \_\_\_\_\_

13. Birthplace Don't know \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Welden \_\_\_\_\_

15. Birthplace Don't know \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edward F. Parks

- (b) Address Augusta Mo

17. (a) Buried (b) Date thereof Jan. 2 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Cath. Cemetery

18. (a) Signature of funeral director Sherry & Son

- (b) Address Augusta Mo

19. (a) Dec 31/40 (b) Galvin Clay  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County St Charles

- (c) City or town Augusta  
(If outside city or town limits, write "RURAL")

- (d) Street No. \_\_\_\_\_ (If rural, give location)

- (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30  
year 1940 hour 530 minute P M.

21. I hereby certify that I attended the deceased from Sept 10, 1937, to Dec 30, 1940

that I last saw him alive on Dec 30, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Arteriosclerosis 5 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertension 5 yrs  
(Include pregnancy within 6 months of death)

Gastric & Bladder hemorrhage 5 yrs

Major findings: 2 days duration

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

- (b) Date of occurrence \_\_\_\_\_

- (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

Signature Galvin Clay (M. D. or other) \_\_\_\_\_  
Address Augusta Mo Date signed 1/7/41

(Licensed Embalmer's Statement on Reverse Side)

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by\_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No.\_\_\_\_\_  
working under my personal supervision.

Signed\_\_\_\_\_

Licensed Embalmer No. 2461

P. O. Address Hamby me

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 43690

Registration District No. 738

Primary Registration District No. 445.3

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County St Charles  
(b) City or town Augusta  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME

Robert L. Parus

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

- (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH

- Month Dec day 30 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death arteriosclerosis Duration \_\_\_\_\_

- Due to \_\_\_\_\_

- Due to \_\_\_\_\_

- Other conditions \_\_\_\_\_ (Include pregnancy within 5 months of death)

- Major findings: Gastric + bladder trouble PHYSICIAN \_\_\_\_\_

- Of operations: 3 days duration

- Due to excessive high blood pressure 260/110

- No evidence of malignancy.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

- (b) Date of occurrence \_\_\_\_\_

- (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

- While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Calvin Olney (M. D. or other)

- Address Augusta Missouri Date signed 2/19/4

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

